TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Pine Creek Medical Center

Respondent Name
New Hampshire Insurance Co

MFDR Tracking Number
M4-16-3822-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
August 25, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Laboratory tests may be (or must be for a non-patient specimen) billed on a 14X claim in the… Based on the 2015 Clinical Diagnostic Laboratory Fee Schedule reimbursement should be… Total reimbursement is $41.57."

Amount in Dispute: $41.57

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Subject to further review, the carrier asserts that it has paid according to applicable fee guidelines and challenges whether the disputed charges are consistent with applicable fee guidelines."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 16, 2016	36415, G0477, G0481	$41.57	$41.57

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the guidelines for reimbursement of professional medical services.
3. The insurance carrier denied payment for the disputed services with the following claim adjustment codes:
   - 197 – Precertification/Authorization/Notification absent
   - 1 – Formatted EOR message unavailable. Event message – Edit used to mark status Q4 codes

- 2 – Processed procedure code is not active on CMS_Addendum_B
- 6 – The charge for this procedure exceeds the fee schedule allowance (Z710)
- Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly. (ZD86)
- W3 – Request for reconsideration

Issues

1. Is the carriers' denial supported?
2. What is the rule applicable to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor seeks payment in the amount of $41.57 for clinical diagnostic laboratory services performed on February 16, 2016.

   The requester billed the following CPT codes;

   - 36415 – Collection of venous blood by venipuncture
   - G0477 – Drug test(s), presumptive, any number of drug classes; any number of devices or procedures, (e.g., immunoassay) capable of being read by direct optical observation only (e.g., dipsticks, cups, cards, cartridges), includes sample validation when performed, per date of service
   - G0481 – Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to, GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem) and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase); qualitative or quantitative, all sources(s), includes specimen validity testing, per day, 8-14 drug class(es), including metabolite(s) if performed

   The services in dispute were denied with the code 197 – "Precertification/authorization/notification absent" at the time of the original adjudication.

   The denial for precertification was not maintained and will not be considered in this review.

   At the time of reconsideration the denial remarks were "Edit used to mark status Q4 codes," and "Processed procedure code is not active on CMS_Addendum_B."

   The meaning of Status Q4 is defined at www.cms.gov, in MLN Matters Number MM9486, Effective Date: January 1, 2016

   > *For CY 2016, CMS is implementing a conditional packaging status indicator "Q4" for packaged laboratory services. Status indicator "Q4" designates packaged APC payment if billed on the same claim as a HCPCS code assigned status indicator "J1," "J2," "S," "T," "V," "Q1," "Q2," or "Q3." The "Q4" status indicator was created to identify 13X bill type claims where there are only laboratory HCPCS codes that appear on the Clinical Laboratory Fee Schedule (CLFS)*

   Addenum B is described as,

   > *Addendum A and B are posted quarterly to the OPPS website. These addenda are a "snapshot" of HCPCS codes and their status indicators, APC groups, and OPPS payment rates that are in effect at the beginning of each quarter.*

   The Division finds the denials utilized are applicable to bill type 131 (OPPS) – "Hospital Outpatient" and not 141 – "Hospital Other Part B" as submitted on the medical claim. Therefore these denials are not applicable and will not be considered in this review.

2. Clinical diagnostic laboratory services are subject to 28 Texas Administrative Code §134.203 (e) which states,

The MAR for pathology and laboratory services not addressed in subsection (c)(1) of this section or in other Division rules shall be determined as follows:

(1) 125 percent of the fee listed for the code in the Medicare Clinical Fee Schedule for the technical component of the service; and,

(2) 45 percent of the Division established MAR for the code derived in paragraph (1) of this subsection for the professional component of the service.

Review of the 2016 Clinical laboratory fee schedule at www.cms.hhs.gov finds;

36415 – Allowable for Texas $ 3.00

G0477 – Allowable for Texas $ 11.36

G0481 – Allowable for Texas $122.99

Total $137.35

No professional component was found for these codes therefore the maximum allowable reimbursement is $137.35 x 125% = $171.69.

3. The total allowable for the services in dispute is $171.69. The requestor is seeking $41.57. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $41.57.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $41.57, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		October 18, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.